Private Medical Insurance Supplement

State Form 51309(4-03)BCD0086

To be completed for all children who are covered by private insurance

Attach a copy of the front and back of the Insurance Card

Child's Name:		·		DOB:	
Last	First		MI		
Child ID:		_	County:		
SC Name:	P	hone Numb	er:	Fax:	
Insurance Carrier:					
Coverage Start Date: Coverage End Date:					
Group Name:					
Group Number:				may or may not have a Group name.	
Policy/member ID:					
Policy Billing Order (Check one):	□ Primary □ Secondary □ Tertiary □ Unknown			If the plan has a POLICY ID, you may or may not have a group name or number	
Insurance Type: Consolidated Omnibus Budget Reconciliation Act (COBRA) Disability Disability Benefits Exclusive Provider Organization Group Policy Health Maintenance Organization (HMO) Individual Policy Medicaid Personal Personal Personal Payment (Cash – No Insurance) Point of Service Preferred Provider Organization (PPO) OTHER: As indicated on the back of this form					
Policy Holder Information (Family Subscriber)					
Name:Last	First	MI	Te	elephone:	
Relationship: (Check one) Father Mother Other	□ Stepfather □ Stepmother		Er	mployer Tax ID:	
Street Address:					
City:		State: _		Zip:	
Date of Birth: Policy Holder Social Security Number:					
The information I have provided is complete and correct to the best of my knowledge. I will notify the First Steps Service Coordinator if there are any changes in my insurance or insurance coverage. Parent Signature: Date:					
Intake/Service Coordinator:				Date:	
Request for Authorization: Total Time spent with the family face to face in completing this form. FCM billing may not exceed 30 minutes per IFSP year.			Original: SPOE EI file Copy: Parent, SC Billing for FCM may be submitted for a total of 30 minutes per IFSP year. Face to face completion of this form may be utilized as FCM billing up to the total maximum. Face to Face completion of the Insurance Consent form may also be utilized toward FCM.		

Complete Listing for Insurance Type: If OTHER is checked on the front page of this form, please indicate which insurance type applies toward coverage:

- □ Medicare Secondary End-Stage Renal disease Beneficiary in the 12 month coordination period
- Medicare Secondary Working Aged Beneficiary or Spouse with Employer Group Health Plan
- Medicare Secondary, No-fault Insurance including Auto is Primary
- Medicare Secondary Worker's Compensation
- Medicare Secondary Public Health Service (PHS) or Other Federal Agency
- Medicare Secondary Black Lung
- Medicare Secondary Veteran's Administration
- Medicare Disabled Beneficiary Under Age 65 with Large Group Health Plan (LGHP)
- Medicare Secondary, Other Liability Insurance is Primary
- □ Auto Insurance Policy
- Commercial
- Medicare Conditionally Primary
- □ Health Maintenance Organization (HMO) Medicare Risk
- □ Special Low Income Medicare Beneficiary
- □ Indemnity
- □ Long Term Care
- □ Long Term Policy
- □ Life Insurance
- Litigation
- Medicare Part A
- Medicare Part B
- Medigap Part A
- Medigap Part B
- Medicare Primary
- □ Other
- □ Property Insurance Personal
- Qualified Medicare Beneficiary
- □ Property Insurance Real
- Supplemental Policy
- □ Tax Equity Fiscal Responsibility Act (TEFRA)
- Workers Compensation
- Wrap Up Policy